Rutland Regional Medical Center
AN AFFILIATE OF RUTLAND REGIONAL HEALTH SERVICES

160 Allen Street
Rutland, VT 05701

802.775.7111

September 17, 2009

Beth Tanzman, Deputy Commissioner
State of Vermont
Department of Mental Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402-0070

Dear Beth:

This is in response to your letter dated September 11, 2009 wherein you requested additional information regarding our proposal.

1. ***Are there any statutory changes you feel would be necessary or important to the proposed program's success? (For instance, non-emergency involuntary medication, admission of court ordered evaluations without physician order and retain in hospital post physician recommendation?)***

Our current proposal is not contingent upon the resolution of these issues. We believe that we can work collaboratively with the State to create clear program expectations that make the best use of the limited inpatient resources and work within the statutory language that exists. Moreover, we envision that when or if the statutes are modified that we can come to agreement with the State on the appropriate changes to the program expectations.

Non-emergency involuntary medication and the admission of court ordered evaluations are two issues that are, nonetheless, of concern to us. From a clinical perspective, we believe that the current process to administer non-emergency involuntary medication is, in many cases, counter to best practice models. With the growing body of knowledge that points to a negative correlation between length of untreated mental illness and treatment prognosis, patients are best served by a legal process that is more timely than the current process. The process historically has averaged over 100 days at VSH. We believe it is possible to find solutions which fully respect the due process rights of patients and provide better care. The psychiatric admission of court ordered patients can occur if they meet acute care criteria.

From an administrative perspective, both issues raise the questions of "medical necessity" and "active treatment" which are required elements of all admissions. Hospitals are not allowed to receive reimbursement from any insurer, including Medicare and Medicaid, for patients who do not meet criteria for medical necessity and who are not participating in active treatment. We also understand that it is not always possible to eliminate these circumstances, such as when a patient refuses medication after admission. In cases where patients no longer meet criteria for acute

inpatient care, we will look to the State contractual agreement to cover the cost of services to these patients.

2. ***Are you willing to admit patients who may require non-emergency involuntary medication?***

The question presupposes that it is possible to definitively determine at the time of admission which patients may require non-emergency involuntary medication. We anticipate that our process for accepting patients from the community (e.g., Crisis Teams, Emergency Departments, etc.) would be very similar our current process and that we would not attempt to screen out patients for whom refusal to take medication was a presenting issue. Having said that, patients currently cared for in another hospital's psychiatric unit who are not receiving active treatment would not be appropriate for transfer to RRMC. They would not meet acute care criteria.

3. ***What are the additional costs for the expansion beds (the pro forma is confusing).***

A proforma showing the existing and new costs is attached. Note that the new programs are significantly more expensive because of the acuity of the patients and the resulting need for additional staff.

4. ***Would the program be fiscally viable at full capacity?***

Yes, if the State provides the level of reimbursement assumed in the financial projections.

5. ***Would you consider more use of RN's rather than LPNs? Please provide a description which defines the roles of RNs and LPNs.***

We have attached job descriptions for an RN and an LPN in our current Psychiatric inpatient unit. In the staffing profile we submitted there were only 2.10 FTE of LPN time identified in the budget. We generally have found that LPNs can serve a niche role between the nursing and psych techs. Generally, when we chose to utilize an LPN we are making a decision that we need a wider range of nursing skill than we would traditionally find with a Psych Tech. In part, the level of FTE in the proposed staffing plan also reflects a proportional increase in the number of LPNs currently employed on the unit. The LPN role in the staffing budget could easily be replaced by increases the budgeted RN and Psych Tech roles. We would, however, preserve any positions currently held by LPNs on our unit on our inpatient unit.

6. ***How do you see this proposed program as part of the larger system to insure that every patient has a bed even if your program is at capacity?***

We anticipate working closely with other providers within the system of care to ensure that patients that are appropriate for step down to a lower level of care transition as soon as beds become available. The mechanisms for coordination of care between levels of care within the system are still in development through the Acute Care Management Project being led by DMH. It will be the expectation of our discharge planning team that they maintain at least daily contact with step-down resources including crisis beds and residential programs. Additionally, it is expected that the inpatient treatment team maintain close contact with the patient's family or

other supports, the outpatient treatment providers, and the primary care providers to coordinate appropriate step down plans.

7. ***What would you do differently from current practice to manage higher acuity and zero reject admission policy in the proposed program?***

The proposed model differs significantly from our current program in the intensity of staffing available and the physical design of the unit. The proposed staffing model anticipates an average number of patients on 1:1 staffing that is proportional to the recent experience of VSH. The core staffing on our current inpatient unit does not include capacity to do any dedicated 1:1 staffing. The proposed unit will also provide a dedicated sub unit for the bedrooms and treatment space for the most acute patients. This separation of spaces will allow us to admit the most acute patients that may require more emergency interventions and 1:1 staffing while maintaining the safety and security of other patients in program. Our current unit design does not offer the ability to fully separate our milieu into, sometimes placing lower acuity patients at risk of re-traumatization due to witnessing the behaviors (and subsequent staff interventions) of the highest acuity patients.

8. ***What community resources and or step-down services are needed for this program to succeed? Please respond both in the context of your immediate community and statewide.***

Ultimately we believe the success of this program will be largely dependent on the ability to transition patients from inpatient levels of care to community based services. Accordingly, the availability of step-down resources is a critical issue. We also know that the current percentage of patients at VSH that do not meet acute care criteria is much larger than would be sustainable by any designated hospital or within the program we are proposing. Without improved coordination of services between the existing levels of care the proposed program would likely be bogged down in the same way. We view the work of the Acute Care Management Project as being vital to the creation of coordinated system of care that can solve this problem.

Currently, 50% of our psychiatric patients come from outside of Rutland County, providing us with a solid understanding of the strengths and challenges of most areas of the State system of care. One of the true strengths of our system of care, in Rutland as well as across the State, is the range and depth of services offered through the CRT program. One of the challenges, however, is that not all services are offered in all areas, and some areas have much greater flexibility and creativity than other areas in meeting patient needs. The core capacities of the CRT programs in each region of the state need to be examined in light of the changing demands on the system of care.

We believe that the work of the Acute Care Management Project needs to create shared responsibility and accountability between the Department of Mental Health, CRT programs and the inpatient hospital to find solutions to complicated discharge planning dilemmas. We need to have performance indicators that track the success of each region's ability to successfully transition patients out of the hospital back into the community. These data need to be monitored closely and active problem solving needs to occur at the case and systems levels.

It is our opinion that the expansion of crisis beds throughout the state is a vital component of maintaining patient flow from the highest levels of care back to the community. Although we have seen an increase in the number of crisis beds available across the state, we have also seen that over the past six months the utilization of these beds has been greater than 70% with an upward trend. At the same time inpatient utilization statewide has been stable with periods when VSH was at maximum capacity. We think that there should be strong consideration given to: 1. creation of dedicated capacity for admissions to these programs for hospital step down; and 2. continued expansion of these programs that ensures services for both CRT and non-CRT patients.

Services for geriatric patients with dementia or significant mental illness present some of most challenging discharge planning cases, as well as some of longest lengths of stay. Specialized outpatient programs or funding to provide trained staffing within nursing homes need to be developed to serve this population. Increasingly, nursing homes are reluctant to take on these high needs patients because the funding available does not match the level of need of the patient.

9. ***Would the program serve individuals referred from the Courts for competency evaluations or from Corrections for acute treatment? Please be explicit regarding forensic admissions.***

We are willing to accept those patients that meet acute care criteria. For example, if a patient needing a competency evaluation also meets the criteria for acute inpatient hospitalization we would be willing to accept the patient for admission. In the case of competency evaluations, it is clear the custody of the patient transfers from the Department of Corrections to the Commissioner of Mental Health, allowing the hospital to seek reimbursement from Medicaid or Medicaid. We are less clear, however, regarding the case of a person from Corrections being referred for active treatment. We are seeking guidance from the CMS Fiscal Intermediary regarding this issue. If CMS deems that the patient/prisoner is ineligible for coverage we would expect the cost of reimbursement for these services to be borne by the State.

10. ***What will you require for medical clearance prior to admission and can you be flexible especially if a patient is refusing medical care or evaluation?***

We currently do not have written guidelines for medical clearance and thus rely on the clinical judgment of each admitting physician to determine what, if any, medical evaluation is necessary prior to admission. Currently, we have a great deal of flexibility with respect to medical clearance of patients and we anticipate maintaining this level of flexibility. An increasing number of our patients come as direct referrals from primary care physicians, community psychiatrists, or community therapists. One of the tasks to be taken up by the Acute Care Management Project is to develop consensus among the designated hospitals regarding medical clearance. We will actively participate in these discussions and expect that we will follow any guidelines developed.

11. ***What additional costs do you anticipate for recruitment of physicians (psychiatrists) and nurses to the Rutland area?***

None. RRMC has a full time physician recruiter and a full HR staff to do the necessary recruitment. We do not anticipate any added expense.

12. ***In the past, RRMC has had difficulty staffing the current unit adequately with psychiatrists. Please provide a five year history of the length of vacancies for psychiatrists during periods of recruitment. If coverage was provided by locum tenems rather than a filled position please identify it as such because it goes to the underlying question of the future ability to sustain adequate coverage.***

Since October 1, 2005 we have had three psychiatrist vacancies within our inpatient unit. The cumulative number of days that a vacancy existed was 501 (16.47 months). The average length of recruitment was 167 days (5.49 months).

13. ***What is the capacity for the "no reject beds" in this proposal – is it 25? 12.5? or 6 beds?***

We will accept any patient that meets acute care criteria and is appropriate for the level of care in which an open bed exists.

14. ***Aside from architectural issues, could the least acute part of the proposed program be an open unit? What is your understanding of how FAHC provides a voluntary option for patients and how might this apply to the proposed program at RRMC.***

Philosophically we are very much in support of the idea of having a truly open unit. FAHC has two very separate units (on different floors) that do not share common milieu space. In the original work that was done regarding unit design, we anticipated sharing common milieu space between the general unit and the secure unit, which creates significant design and policy challenges that would need to be overcome. We are very open to more fully exploring these options.

15. ***The space that the psychiatric program currently uses would become available to RRMC for alternative uses if the proposed program were created. What is the value of that space and how would you include this calculation in the costs of the new service to the State?***

Approximately 8000 gross square feet will become available. That space will be used for support staff currently employed by the hospital. We do not anticipate new revenue created in that space. Consequently there is no offset to the facility costs contained within the proforma.

16. ***When will you reflect the actual payer mix for VSH patients rather than an assumption?***

Once we are able to examine the charts and patients currently housed at the VSH a better estimate can be done. Given that for many patients an active billing process has not been completed at VSH we can not rely on that financial data alone. We will not know the complete accuracy of these numbers until the program is up and running. That is one reason we have agreed to share all financial data with the State on an ongoing basis and to have a reconciliation process which reflects actual experience.

17. Please describe in more detail your philosophy of care.

Please see the attached Operational Framework.

18. The current RRMC program developed an extreme policy in response to a recent regulatory requirement (the policy on strip searches for all admissions). Please explain this and how future such issues will be approached.

As result of findings by CMS, RRMC implemented a policy on searches that met the reviewer's expectation that we "ensure the safety of all of your patients." Moreover, there was also an expectation by CMS that the policy be developed and implemented immediately. The policy developed was accepted by CMS during their visit as adequate to meet their expectations and was not inconsistent with practices elsewhere in the country. There was nothing in our conversations or other communication with CMS that even remotely suggested that the policy was anything more than minimally adequate in ensuring safety, let alone extreme in any way.

Following the CMS visit and creation of the policy, Psychiatric Services leadership brought the policy for review and discussion to the very next Community Advisory Committee (CAC) meeting. The feedback from consumers and advocates was essential to ultimately creating a policy that balanced the demands of CMS with practice that more accurately reflected our treatment philosophy and values. Going forward, we see transparency we have tried to achieve between our operations and the CAC as being critical to appropriately addressing any future such issues.

19. How will the proposed program provide access to ECT?

We anticipate that access to ECT will require a transfer of the patient to a hospital that provides that service such as Fletcher Allen Health Care, Central Vermont Medical Center, or the Brattleboro Retreat.

20. RRMC has made great changes in the psychiatric unit but these changes have not been observed in the Emergency Department and other areas of the hospital. How will consistency be created between the values of the psychiatric unit and the rest of the hospital?

We agree that changes need to continue to be made in the Emergency Departments interaction with the psychiatric unit, crises directors and patients. Tom Huebner and Jeff McKee are taking a lead on this effort, working with Dr. Kirk Dufty, ED Medical director, and Pat Skidmore, ED Nurse Director. Specific concerns from the Committee would be helpful and should be brought to our attention.

21. Will you rely on security guards for management of acute psychiatric patients requiring restraint or seclusion?

It is anticipated that most seclusion and restraint situations will be fully managed by unit staff. However, when needed, Hospital Security will be available to assist unit staff, particularly at night when staffing levels are lower.

22. Does the current financial crisis impact on this proposal? In the past, RRMC has communicated that the psychiatric service would be closed due to financial issues.

It does not affect this proposal but financial crises can affect the program over time. The current program makes a modest contribution to overhead at RRMC. As noted below we are very committed on the long term to this program. We are committed if it can be done well. This will require the reimbursement from the State to be sufficient, as shown in our proforma.

23. What is the long term commitment to continue to provide this level of care?

The management and Board are committed to this project. It is not often that we have an opportunity to dramatically improve the system of care to our patients. This is one of those moments. It is not a moment we should miss.

24. Can you provide an onsite facility for court hearings?

We believe that we could easily accommodate court hearings for our patients within the proposed program. In fact, we would be delighted to have court hearings for our patients provided on site. This reduces stress on patients and staff and removes a variety of logistical and safety challenges related to transport of unstable patients.

If you have any further questions please do not hesitate to ask.

Sincerely,

Thomas W. Huebner
President

TWH:cn
Enclosures

Rutland Regional Medical Center
Psychiatric Services Inpatient Unit
160 Allen Street
Rutland, VT 05701
(802) 747-3715, FAX (802) 772-2448

OPERATIONAL FRAMEWORK
FY 2009

I. Mission

A. Departmental Mission

1. Life presents us all with an ever changing set of challenges. Our goal is to help people deal with the bio-psycho-social struggles and complexities of being human. This encompasses a spectrum from wellness to illness.

   In a community-based, caring and committed environment, we provide: competent and holistic specialty care for the purpose of stabilization; progress towards achieving optimum level of wellness; education; and access to related services for individuals and their families, physicians and other institutions.

B. Vision

1. In keeping with the over arching goal of RRMC "To be the best community hospital and health service in New England." It is the goal of the Psychiatric Services Department to be the best community hospital based Psychiatric Services system in New England.

C. Our Goals

1. *Quality:* We will provide high quality health services which satisfy our customer needs through good clinical outcomes, leading technology, efficient processes, competent and caring staff and well maintained facilities.
2. *Growth:* We will develop new services and expand existing services to meet customer needs resulting in increased market share and expansion into new markets.
3. *Financial Strength:* We will achieve financial strength and stability by improving reimbursement, increasing philanthropic giving and grants and developing and managing realistic budgets which produce sufficient margins
4. *Employer of Choice:* We will create an environment where employees: trust those they work for; enjoy those they work with; take pride in what they do; and have an opportunity to grow.

D. Treatment Philosophy

1. The PSIU staff with involvement from the Community Advisory Committee established the following operational philosophy. "We believe that recovery is possible for all people. We provide patient-centered care in a mutually respectful, collaborative environment."
2. The hospital provides 24-hour emergency crisis care, as well as psychiatric intensive care, medical detoxification, and treatment of simultaneous substance abuse and behavioral health disorders. People living with depression, stress, addictions, memory problems and other conditions receive compassionate treatment from Rutland Regional Medical Center's behavioral health professionals. Specialized inpatient and outpatient treatment programs help patients manage symptoms, learn coping skills and experience empathic support. Family members and friends also are encouraged to participate in treatment and to provide input that will assist patients with their recovery. During and after treatment, patients benefit from referral management and support services.

3. The Psychiatric Services Inpatient Unit (PSIU), located at Rutland Regional Medical Center, is a 19-bed short-term secure medical psychiatric unit. Our service is licensed to treat adults 18-years and older who require psychiatric treatment in an acute inpatient setting. Given our location within a general hospital setting, access to medical and surgical specialties, and the advanced training of our own staff, we are able to provide concurrent treatment of psychiatric disorders and co-existing medical conditions.
4. We are committed to the philosophy that the needs of the patient are best served by the thoughtful integration of specialized services delivered by a multidisciplinary team of professionals. It is our belief that each individual be treated with the utmost dignity and respect. With the involvement of the individual and his/her family, we aim to tailor a treatment plan that offers optimal care to each patient. The team's philosophy is to apply treatments with a strong foundation of evidenced-based approaches. The inpatient hospital milieu and staff provide a level of support 24 hours a day, seven days a week that allows the patient to do the difficult work that is required for the treatment to be effective.
5. Upon admission, the team conducts an assessment and aids the patient in creating clear treatment goals. An integrated plan of care specifies how the treatment team will support the patient in addressing the presenting issues and is reviewed daily. All behavior plans are made as collaborative efforts between the treatment team and the patient. To support the patient in this intensive work, the staff and overall milieu foster an atmosphere for change that enables the patient to engage in developing new or enhanced coping mechanisms. This atmosphere results from the blend of support and encouragement from peers and the multidisciplinary team who provide feedback and assistance in meeting treatment goals.

II. Responsibility

A. The Chief Medical Officer is responsible for maintaining continuing review of professional performance of all physicians within the Psychiatric Services section.
B. The Medical Director of Psychiatric Services and the Director of Psychiatric Services are responsible for assuring the quality and appropriateness of services provided.
C. The Psychiatric Services Section Chief is responsible for participating in peer review activities, clinical case presentations and review as well as analysis of trend data.
D. The Director of Psychiatric Services is responsible for planning, managing and marketing programs within the Psychiatric Services Department. He/She facilitates and coordinates the overall development and operation of assigned services and directs those services to provide comprehensive, cost-effective care.
E. The Director of Nursing and other supervisory staff are responsible for day to day operations within Psychiatric Services. They assist the Director of Psychiatric Services in the planning and implementation of goals to maximize continuous quality improvement.
F. Staff members are responsible for quality improvement by participation in Psychiatric Services' ongoing staff development activities, interdisciplinary projects and implementation of services to improve the quality of service.
G. The Quality Management Coordinator serves as a resource and provides support to the clinical quality improvement and risk management activities. He/She is responsible for coordination of psychiatric staff quality improvement monitoring.
H. The Utilization Review Coordinator works with the team and managed care to ensure appropriateness of continued hospitalization.

III. Scope of Service / Key Clinical Services

A. Includes all patients who receive services from Rutland Regional Medical Center Psychiatric Services Department
B. Important functions include:
    1. Multidisciplinary team approach.
    2. Medical / Psychiatric assessment
    3. Psychopharmacology
    4. Milieu Therapy emphasizing active coping skills and empathic support (DBT Model)
    5. Comprehensive individualized treatment
    6. Advocacy for patient's rights plan
    7. Family involvement / education / therapy
    8. Group therapy emphasizing coping skills (DBT Model)
    9. Occupational Therapy consultation and evaluation

C. Scope of Psychiatric services include:
    1. Voluntary inpatient
    2. Involuntary inpatient
    3. Consultation / liaison
    4. Dual diagnosis treatment

D. Care providers within Psychiatric Services include:
    1. Physician
    2. Clinical Psychologist
    3. Psychiatric Nurse Practitioner
    4. Masters prepared counselor
    5. Crisis clinician
    6. Social Services – discharge planner
    7. Occupational Therapist
    8. Nurse practitioner
    9. Certified RN and/or LPN
    10. Nurses aid

IV. Assignment Staffing

A. Documentation of individual skills and competencies is done at the time of orientation and through the annual performance appraisal process.
B. Mandatory skills sessions are provided regularly by the Education Department for yearly maintenance of cardiopulmonary resuscitation, safety, and infection control and crisis prevention intervention. All staff are required to practice universal precautions.
C. RRMC has a credentialing process for all licensed professionals that includes monitoring of licensure status. Funding is provided for staff training on topics relevant to a staff person's current work or to an area of professional growth identified on the staff person's annual performance review.
D. There is cascading of priorities from Hospital work plan to departmental work plan to individual staff professional development plan that guides the prioritization of supported education. Frequently these trainings provide continuing education credit that can be used to meet licensing requirements. Additionally, tuition reimbursement of $1,600 per year is available for staff taking formal course work.

E. PSIU provides annual training and assessment of competency for all direct care staff in the following areas identified below. Completion of these competencies is documented in annual performance evaluations.
   1. Mini Mental Status Exams,
   2. Involuntary Movement Assessment,
   3. Seclusion and Restraint,
   4. CPI,
   5. Patient Searches,
   6. Clinical Documentation, and
   7. Involuntary Patient Status.

V. Important Aspects of Care

A. The Psychiatric Services Inpatient Unit treatment team combines psychiatric and emotional support to create a collaborative approach to assist with life's challenges. Patients and families are a key component to the focus and development of treatment and every patient will be given the opportunity to meet with their treatment team. Treatment plans may include:

- Daily meetings with the Treatment Team
- Medication management
- Psychotherapy
- Groups therapy
- Relapse Prevention Plan
- Family/Support Meeting
- Milieu treatment

B. **Treatment Teaming**

Monday through Friday all patients are expected to meet with their treatment team, led by the attending psychiatrist. Other members of the treatment team that are typically present include a Social Worker/Counselor and a Nurse. Other members of the staff may participate at the request of the team or the patient. At the patient's discretion, family members or other supports may also participate.

The treatment team meetings allow an opportunity the patient to discuss their treatment and discharge plans with the entire team. Changes to the treatment plan, including medication adjustments, typically happen at these meetings. The input and perspective of each patient is essential to the overall treatment success.

C. **Medication management**

Among the techniques are "biological" treatments, particularly the use of medications. Psychopharmacological treatment (medication) has proven to be very effective in the care of anxiety, panic, obsessive-compulsive and mood (depression and bipolar) disorders, as well as with psychotic illnesses.

D. **Psychotherapy**

Another technique is "psychotherapy," or "talk therapy," during which the clinician gains insight into and understanding of the patient's problems and usual ways of dealing with them. The therapist helps the patient use this new understanding to manage problems more effectively in the future.

E. **Group therapy**
In addition to individual therapy sessions, group sessions are also an important part of the patient's treatment plan. Some groups are based on psychotherapy techniques with a focus on how the patient is feeling "here and now." Some are more educationally oriented. Still others are focused on motor skills and activities, such as group outings or exercise classes. The treatment team will discuss with the patient which groups are best suited to his/her needs.

F. **Relapse Prevention planning**
Recovering from mental illness takes time. You did not develop mental illness or addiction over night and it will not go away that quickly either. It is important to remember that no one can recover perfectly and there will be slips and relapses during the recovery process. This is normal and it is to be expected. The Relapse Prevention Plan is something patients may find helpful in preparing for and preventing a relapse. Such a plan may make the difference between a mild flare-up of symptoms and a full-blown relapse of our addiction and psychiatric illness.

G. **Family/Support Meetings**
Family support meetings are usually facilitated by your Social Worker/Counselor and/or psychiatrist. The purpose is usually twofold. First, it is often helpful for patients and families to express their feelings about the stresses and challenges of recent events. Through facilitated conversation patients and families can often come to better understanding of each other's needs as they seek to re-establish a healthy lifestyle. Second, there are often many aspects of follow-up care that require coordination and support. The Social Worker/Counselor will be able to explain both the purpose and value of any recommended aftercare. They will also work with the family to help overcome barriers to follow-up treatment such as child care, transportation, or financial support.

H. **Milieu Therapy**
A third approach is "milieu therapy," in which the patients and the staff on the unit are considered a whole community in themselves. Patients learn about themselves by participating in the life of the "unit" community, resolving its everyday problems and achieving its goals. The milieu provides structure, safety, mutual support and caring, and encourages active participation in an open flow of communication and feedback.

VI. Quality management Objectives

A. To identify and address quality problems
B. To identify and monitor trends in the clinical areas utilizing Clinical Indicator Monitoring.
C. To address identified areas for continued education.
D. To provide information for use in evaluation for reappointment and re-credentialing.
E. To identify high risk or safety issues and facilitate appropriate intervention.
F. To identify patterns of performance that indicate a need for improvement.

VII. Quality Indicators

A. Indicators to be monitored will be developed by the Section, the Medical Director, Director, Team and Clinical Leaders, based on volume, problem prone areas, high risk areas, previous data, newly implemented services and staff input.
B. Areas to be monitored will include the following:
   1. Use of Emergency Interventions (e.g., Seclusion, Restraint, Emergency Meds)

2. Patient Satisfaction Surveys (e.g., Press-Ganey)
3. Critical Incidents
4. Complaints and Grievances
5. Compliance

VIII. Monitoring of Quality Management Progress

A. Findings identified through indicator monitoring or issues of concern will be reviewed at Section.
B. The QM Coordinator will refer cases with potential liability and /or quality concerns to the Medical Director or Director of Psychiatric Services.
C. Documentation of monitoring and evaluation, conclusions, recommendations, and action will be documented in quarterly reports.
D. Results of review activities within Psychiatric Services will be reported quarterly and will be disseminated to the Section Chief, Hospital Administration and the Quality Committee of the Board of Directors, and Sections meetings.

IX. Annual Appraisal

A. The effectiveness, objectives, scope, organization and implementation of the Psychiatric Services Operational Framework will be evaluated annually.

Signature:_____ Date:_____
Lesa M. Cathcart, RN, MS,
Director of Nursing - Psychiatry

Signature:_____ Date:_____
E. Susan Gerretson, MD,
Medical Director - Psychiatry

Signature:_____ Date:_____
Jeffrey D. McKee, Psy.D.,
Director of Psychiatric Services

Signature:_____ Date:_____
Thomas J. Huebner
President, Rutland Regional Medical Center

Licensed Practical Nurse (139)

JOB DESCRIPTION

Date: 6/1/09	**Last revision date:** 6/1/09
Department: Various	**Reports to:** Director of Nursing or Clinical Manager

POSITION SUMMARY

The Licensed Practical Nurse will utilize the nursing process by assisting the Registered Professional Nurse in providing individualized patient care.

ESSENTIAL FUNCTIONS

Essential functions are those tasks, duties, and responsibilities that comprise the means of accomplishing the job's purpose and objectives. Essential functions are critical or fundamental to the performance of the job. They are the major functions for which the person in the job is held accountable. Following are the essential functions of the job, along with the corresponding performance standards.

1. **Collects, communicates, documents age specific patient health status data in a systematic manner:**

   a. Provision of direct patient care. Obtain information through observation and communication with patients and family.
   b. Documents patient information according to Nursing Policy.
   c. Respects the need for accurate information while preserving the right to privacy and the need for confidentiality for all customers.
   d. Cooperates and collaborates with all members of the Health Care Team to meet the needs of family centered nursing care.

2. **Under the direction and supervision of the RN, provides care to meet age specific needs of patients in areas of:**

   a. Safety.
   b. Hygiene.
   c. Nutrition.
   d. Medication.
   e. Elimination.
   f. Psycho-social and cultural.
   g. Provides instruction and explanation concerning procedures.
   h. Provides instruction for patient/family to facilitate discharge.
   i. Administers patient medications.
   j. Transcribes MD orders.
   k. Accepts and documents verbal and/or telephone orders.
   l. Parenteral procedures – specific areas of responsibilities:
      i. Maintenance of IV lines and solution.
         After further education, will hang pre-mixed IV admixture solutions and maintenance of those lines.

3. **Blood Administration:**

   a. Maintains blood and blood component administration after the initiation of the transfusion by an RN according to hospital policy.

4. **Practices principles of Infection Control utilizing aseptic technique as appropriate measures.**

5. **Recognizes changes in patient condition and emergent signs and symptoms and initiates**

appropriate measures.

6. **Accurate on-going documentation is consistent with the plan of care on all appropriate forms according to hospital policy.**

7. **Adheres to the tents of the RRMC Privacy and Confidentiality statement in all aspects of the position, duties and responsibilities.**

8. **Develops awareness of utilization of time and material that will increase efficiency while minimizing costs to the patients.**

9. **Maintains accountability for practice, education and behavior as related to healthcare:**

   a. Demonstrates work schedule flexibility to meet unit needs.
   b. Assumes designed patient care assignment on whatever unit is assigned.
   c. Promotes a positive image of nursing in all interactions.
   d. Demonstrates behaviors consistent with the organization's values.
   e. Complies with RRMC personnel policies and Unit Operational Framework.
   f. Understands and applies ethical and legal concepts to nursing practice.
   g. Maintains Hospital Mandatory Skills, unit specific requirements and CPR certification on an annual basis.

10. **Practices personal and hospital safety:**

    a. Demonstrates role during fire and other codes.
    b. Practices universal precautions and isolation techniques.
    c. Demonstrates responsibility in emergency situations and acts accordingly.
    d. Participates in committees that impact on unit, department and organization.
    e. May be asked to "float" to other nursing units to meet patient needs. The responsibilities and expectations remain the same regardless of assignment.
    f. Provides direct patient observation when required in any nursing department.

11. **Attends all required safety training programs and can describe his or her responsibilities related to general safety, department/service safety, and specific job-related hazards.**

12. **Follows the hospital exposure control plans/blood borne and airborne pathogens.**

13. **Demonstrates respect and regard for the dignity of all patients, families, visitors, and fellow employees to ensure a professional, responsible, and courteous environment.**

14. **Promotes effective working relations and works effectively as part of a department/unit team to facilitate the department's/unit's ability to meet its goals and objectives.**

15. **Demonstrates Commitment to Patient Safety**

    a. Understands and follows the organization's patient safety-related policies, procedures and protocols.

    b. Demonstrate proactive approach to patient safety by seeking opportunities to improve patient safety through questioning of current policies and processes.

    c. Identify and report/correct environmental conditions and/or situations that may put a patient at undue risk.

d. Report potential or actual patient safety concerns in a timely manner per the organization's protocol.

16. Acts as a Corporate Citizen

a. Acts with integrity by adhering to policies and compliance requirements consistently and openly reports concerns to Leadership without fear of retaliation.
b. Is aware of the legal, regulatory and accreditation requirements that apply to their area.
c. Proactively promotes a common well-being of the organization by encouraging activities and behaviors and by being a role model in support of the organization's mission, vision and values.

17. Other duties as assigned.

JOB REQUIREMENTS

Minimum Education	▪ High School graduate or equivalent. ▪ Graduate of an approved School of Practical Nursing.
Minimum Work Experience	▪ Previous hospital or nursing home LPN experience preferred. ▪ Demonstrated proficiency in acute care nursing, knowledge and skills.
Required Licenses/Certifications	▪ Licensed or eligible for in the State of Vermont, or as stated in Title 25, V.S.A., Chapter 27, #1555. ▪ All Licensed Practical Nurses hired after November 1984 must have documented medication experience, and obtain medication certification. ▪ CPR certification preferred
Required Skills, Knowledge, and Abilities	▪ Able to institute life saving measures. ▪ Effective written and verbal communication skills are required and the ability to interact with a variety of customers groups.

CONTACTS

Supervises	___x___ No supervisory responsibilities _____ Approx. number of direct reports _____ Approx. number of indirect reports
Age of Patient Populations Served *(check all that apply)*	___x___ Neonates 1 – 30 days ___x___ Infants 30 days – 1yr. ___x___ Children 1 – 12 yrs. ___x___ Adolescents 13 – 18 yrs. ___x___ Adults 19 – 70 yrs. ___x___ Geriatrics 70+ _____ No patient contact
Internal Contacts *(check all that apply)*	___x___ Patients ___x___ Providers (i.e., physicians) ___x___ Staff (i.e., clinical and support staff) ___x___ Volunteers _____ Others: _____
External Contacts *(check all that apply)*	___x___ Patients ___x___ Providers

	___x___ Vendors ___x___ Community agencies and advocates ___x___ Regulatory agencies _____ Others: _____

OVERTIME STATUS

_____ Exempt (salaried – not eligible for overtime)
____x__ Nonexempt (hourly – eligible for overtime)

PHYSICAL REQUIREMENTS

Indicate the appropriate physical requirements of this job in the course of a shift.
Note: Reasonable accommodations may be made for individuals with disabilities to perform the essential functions of this position.

General Activity

	% of Shift				
	75-100	50-75	25-50	≤ 25	None
Stand/Walk	__X__	_____	_____	_____	_____
Sit	_____	_____	__X__	_____	_____
Drive	_____	_____	_____	_____	__X__

Motion

	Up to 1/3 of time	1/3 or more of time
Bend	_____	__X_
Squat	_____	__X_
Crawl	_____	_____
Climb	_____	_____
Reach	_____	__X_
Lift	_____	__X_
Carry	_____	__X_
Push	_____	__X_
Pull	_____	__X_

Use of Hands/Feet

	Gross Motor Function	Precise Motor Function (Or Fine Manipulation)
Right Hand	___X__	___X__
Left Hand	___X__	___X__
Right Foot	___X__	_____
Left Foot	___X__	_____

Weight Lifted/Force Exerted
Indicate how much weight or force and how often by checking the appropriate boxes.

	Up to 1/3 of time	1/3 or more of time
Up to 10 pounds	_____	_____
Up to 25 pounds	_____	_____
Up to 50 pounds	_____	__X_
Up to 100 pounds	_____	_____
More than 100 pounds	_____	_____

Body Fluid Exposure

_X Yes
___ No

List any other physical

Physical Demands: Significant periods of standing, moving about, walking,

requirements:	lifting, stretching and pulling. Must be able to lift or push up to 50 lbs. Environmental Demands: A class 2 level of exposure to blood-borne pathogens, body fluids. Exposure to bio-hazardous materials. Mental Demands: Stress of uneven work volume, performing several tasks to a defined deadline, pressure of remaining calm during frequent interruptions from work volume changes and customer service. Manual Dexterity: Mental and visual concentration which must be sustained throughout the work day.

MENTAL AND EMOTIONAL REQUIREMENTS

Indicate the mental and emotional activities required of this job in the course of a normal shift (check all that apply).

__x__ Handles multiple priorities

__x__ Independent discretion/decision making

__x__ Makes decisions under pressure

__x__ Manages anger/fear/hostility

__x__ Manages stress appropriately

__x__ Works alone effectively

__x__ Works in close proximity to others and/or in a distracting environment

__x__ Works with others effectively

Rutland Regional Medical Center
160 Allen Street
Rutland, VT 05701

POSITION DESCRIPTION
2003

POSITION TITLE: Registered Nurse

DEPARTMENT: NURSING

COST CENTER: JOB NUMBER: #

DOT CLASSIFICATIONS

H.R. USE ONLY	EXEMPT		DATA/PEOPLE/THINGS	
	NON-EXEMPT		STRENGTH	
	PAY GRADE		WP	
	HOURLY		SVP	
	APPROVED BY		DATE	1/05

The following description is intended to describe the general nature and work being performed by people assigned to this job. It is not intended to be an exhaustive list of all responsibilities, duties and skills required of personnel so classified.

POSITION SUMMARY: In one or two sentences, describe the primary function and purpose of this position.

The Staff Nurse is responsible for the coordination and provision of direct patient care utilizing the nursing process. The Staff Nurse operationalizes the objectives, policies, and procedures of the Medical Center and Clinical Services for a specific shift.

DUTIES AND RESPONSIBILITIES: In determining if a function is essential, consider the frequency with which a function is performed, the amount of time spent on the function, and the consequences if the function is not performed.

ESSENTIAL POSITION FUNCTIONS	% TIME	FUNCTIONAL JOB DESCRIPTION
▸ Collects, communicates, documents, and interprets age specific patient health status data in a systematic manner.		
▸ Utilizes effective interviewing skills to obtain a complete patient history according to Nursing Policy - "Patient Assessment."		
▸ Carries out a complete and accurate physical assessment according to Nursing Policy.		
▸ Utilizes collected data to: a) initiate a discharge plan b) initiate appropriate referrals c) initiate appropriate Plan of Care.		
▸ Documents collected data according to hospital policy, including assessment intervention and outcome.		
▸ Develops a plan of care and teaching plan to achieve patient and family goals. ▸ Coordinates patient care to achieve identified goals from admission to discharge through collaboration with physician and multidisciplinary team members. ▸ Develops goals which are consistent with the medical Plan of Care. ▸ Revises goals as appropriate to patient status.		

▸ Establishes priorities for nursing actions. ▸ Organizes nursing actions in a logical sequence.		
▸ Demonstrates safe theory-based nursing practice consistent with hospital policies and professional standards. ▸ Practices principles of infection control utilizing aseptic technique as appropriate, and practicing Universal Precautions. ▸ Administers medications and is responsible for all aspects of that administration as outlined by the nursing policy/procedures. ▸ Administers IV therapy and is responsible for all aspects of that administration as outlined by the nursing policy/procedures. ▸ Assumes responsibility for all aspects of IV blood and blood components administration. ▸ Recognizes changes in patient conditions and emergent signs and symptoms and initiates appropriate measures. ▸ Demonstrates knowledge of the principles of growth and development over the life span. Possesses the ability to assess data reflective of the patient's status and interprets the appropriate information needed to identify each patient's requirements relative to his/her age-specific needs.Provides the care needed by each patient group, i.e. neonate, pediatric, adolescent and/or geriatric age group.		

▸ Evaluates patient responses as compared to desired outcomes and documents the degree of goal attainment and revises the plan of care as required. ▸ Actively participates in Quality Improvement activities: a) Chart review. b) Committee involvement c) Identifies and participates in systems improvements.		
▸ Maintains accountability for practice, education and behavior as related to professional nursing. ▸ Assumes responsibility and accountability for individual nursing judgments and actions. ▸ Demonstrates work schedule flexibility to meet unit needs. ▸ Identifies own continuing education needs and assumes responsibility to seek out and attend educational programs. ▸ Promotes a positive image of nursing in all interactions. ▸ Demonstrates behaviors consistent with Service Excellence principles. ▸ Complies with RRMC personnel policies and Unit Operational Framework. ▸ Understands and applies ethical and legal concepts to nursing practice. ▸ Maintains Hospital Mandatory Skill, and unit specific requirements on an annual basis.		

▸ When serving as the nurse in charge for a designated shift, the following behaviors are expected: a) Conducts shift report and makes staffing assignments based on staff competence. b) Assignment of admission based on staff competence. c) Communicates with members of the multidisciplinary team. d) Performs or designates emergency cart checks and other unit specific shift requirements. e) Defines roles and coordinates personnel activities during emergency situations. f) Makes patient rounds and receives periodic reports from staff members as to current patient status. g) Assists staff members in problem solving and decision making concerning clinical and non-clinical situations. h) Assures adequate staffing levels to insure quality patient care. ▸ Demonstrates continued professional growth through various modalities such as: specialty certification, continuing education,and membership in professional organizations.		

KNOWLEDGE AND SKILL REQUIREMENTS

(a) Describe the kinds of specialized or technical knowledge, skills, experience and education which are essential to performance. Education should be expressed with phrase "or equivalent."

1. Education: Graduate of an approved school of nursing, licensed in the State of Vermont.

(b) Describe to what extent the position requires a knowledge of medical center policies, procedures, and organization practices.

Leads by example, serving as a role model; building the culture by demonstrating desired behaviors. Demonstrates intra and interdisciplinary knowledge. Transcends turf barriers, thinks globally and promotes "we" thinking. Knows and support RRMC values, strategic plan, vision and mission in the changing environment. Challenges status-quo thinking; is visionary and future focused.

C) Describe the nature, extent and purpose of contacts with internal and external customers necessary to carry out the responsibility of this position. Communication skills should be described, both oral and written.

Is patient/customer focused. Organizes, possesses and maintains records and other forms of information in a systematic manner. Works and communicates with customers to satisfy their expectations. Demonstrates active listening skills; creates and maintains open lines of communication. Attends unit staff meetings. Supports service excellence as a customer relations strategy by ensuring that attitude and actions of self and staff is consistent with the shared leadership behaviors. Evaluates operations from a workflow perspective that cuts across multiple boundaries; redesigns processes with knowledge of customers' needs and competitive benchmarks. Provides and receives continual feedback and ongoing assessment of performance.

JOB DIFFICULTY

(a) Describe the type and extent of problem-solving required in carrying out the position responsibilities. Illustrations should show the ingenuity, complexity, resourcefulness, analysis, or creativeness required.

Demonstrates initiative and creativity; generates new responsibilities and solutions to various situations. Takes ownership of issues; follows through on commitments and gets results. Respects the differences and diversity in individuals and groups; is sensitive to their needs. Works toward agreement by utilizing effective conflict resolution and negotiation skills. Distinguishes trends, predicts impact of actions on systems/processes, identifies variances of a system/organization and takes action to correct performance. Knows own emotional capacity and stress level and how to address them.

(b) Describe decisions and/or recommendations which are an essential part of the position.

Allocates time through prioritization; understands, prepares and adheres to schedules, deadlines and time lines. Uses sound judgment, is decisive and effective in searching conclusions; helps people to understand reasons for decisions. Pursues opportunities for professional and personal growth.

Working Conditions:

Physical Demands: Significant periods of standing, moving about, walking, lifting, stretching and pulling. Must be able to lift or push up to 50 lbs.

Environmental Demands: A class 2 level of exposure to blood-borne pathogens, body fluids. Exposure to bio-hazardous materials.

Mental Demands: Stress of uneven work volume, performing several tasks to a defined deadline, pressure of remaining calm during frequent interruptions from work volume changes and customer service.

Manual Dexterity: Mental and visual concentration which must be sustained throughout the work day.

ACCOUNTABILITY

(a) Describe the impact that this position has on quality improvement within the department and medical center, the impact on preserving the medical center's image, and any benefit to the community.

Pursues opportunities for professional and personal growth. Participates in performance improvement projects.

(b) Indicate the extent to which this position directly or indirectly influences financial planning, revenues, and/or cost containment.

Evaluates the risk/benefit ratio of new ideas. Understands and assists others in the understanding of the fiscal responsibility of RRHS.

C) Describe the responsibility of the position for the maintenance and security of equipment and supply items.

Judges procedures, equipment, and technology that will produce desired results.

(d) Determine the impact that this position has on the safety or well being of those within the medical center.

Plans, organizes, and delegates work effectively. Assesses own knowledge and skills; recognizes their capabilities to further RRHS's vision. Facilitates teamwork by working with others; contributes ideas, suggestions and efforts to the group. Promotes learning, growth and change by example and creates an environment that enhances this; encourages and rewards creativity. Exceeds customer expectations and promotes a positive and collaborative environment in which quality improvement abounds.

SHARED LEADERSHIP SKILLS

Teamwork/Adaptibility:

- Works to resolve workplace conflicts.
- Supports organizational and team goals and endeavors. Receptive to change/new ideas.
- Focuses on performance, rather than personality in relating to others.
- Recognizes own strengths and limitations.
- Recognizes strengths and limitations of others.

Interpersonal Relationships/Customer Services:

- Interacts positively with a variety of people in different situations.
- Receptive to suggestions/feedback.
- Works cooperatively and effectively with others.
- Services customers in a manner that increases their confidence and knowledge.
- Demonstrates professionalism, courtesy and respect to customers and co-workers.
- Behavior reflects a desire to do a good job.
- Demonstrates self-confidence and positive attitude toward self and others.
- Seeks to clarify and confirm the accuracy of information, idea or direction given.
- Makes oral and written communication clear and easy to understand.
- Meets the standards of behavior required by the RRHS policy on Privacy and Confidentiality.

Planning, Organizing, and Goal-Setting:

- Demonstrates effective use of time and resources.
- Effectively sets goals and establishes priorities consistent with organizational/team objectives.
- Meets deadlines.
- Effectively manages tasks or program assignments including follow-through and delegation.
- Alerts appropriate team member if deadlines need to be renegotiated to accomplish work with a higher priority.

Problem-Solving and Decision-Making:

- Effectively identifies problems and evaluates alternative solutions.
- Makes quality decisions consistent with skills and experience.
- Recognizes decisions that have to be deferred until all pertinent facts are gathered and analyzed.
- Flexible in modifying decisions.
- Ensures all affected stakeholders are involved in problem-solving and decision-making.
- Makes decisions in a timely manner.

Dependability/Creativity/Initiative/Resourcefulness:

- Independently contributes ideas and projects within established guidelines.
- Collaboratively works toward solutions.
- Takes on new responsibilities/opportunities.
- Adapts to change.
- Effectively utilizes available resources in the organization.
- Attempts to simplify and/or improve procedures and techniques.
- Initiates new and creative ideas or procedures to enhance the department or organization.

JOB DEMAND ANALYSIS

Mark the "Frequency" which applies. Frequency is based on how much an activity occurs in an 8 hour work day. If a specific job demand occurs continuously [67-100%] use "C", frequently [34-66%] use "F", occasionally [6-33%] use "O", rarely [1-5%] use "R". If it never occurs, leave it blank. Then mark the appropriate "Function" box. Use "E" if the specific job demand is essential, use "M" if it is marginal.

REQUIRED PHYSICAL CAPABILITIES

REQUIRED PHYSICAL CAPABILITIES	FREQUENCY C/F/O/R	FUNCTION E/M	REQUIRED PHYSICAL CAPABILITIES	FREQUENCY C/F/O/R	FUNCTION E/M
1. Standing	F	E	18. Balancing	---	---
2. Walking	F	E	19. Running	---	---
3. Kneeling	R	M	20. Feeling	C	E
4. Twisting	F	E	21. Crouching	---	---
5. Driving	---	---	22. Carrying	R	E
6. Writing	C	E	23. Grasping	---	---
7. Reacting	C	E	24. Pinching	---	---
8. Talking	C	E	25. Use Both Feet	C	E
9. Sitting	F	E	26. Use Both Hands	C	E
10. Bending	F	E	27. Use Knees	C	E
11. Climbing	---	---	28. Reaching	O	E
12. Throwing	---	---	29. Pushing	O	E
13. Jumping	---	---	30. Pulling	O	E
14. Handling	O	E	31. Lowering	O	E
15. Turning	F	E	32. Lifting	F	E
16. Stooping	O	E	33.		
17. Crawling	---	---	34.		

EQUIPMENT & TOOLS

EQUIPMENT & TOOLS	FREQUENCY C/F/O/R	FUNCTION E/M	OBJECTS MANIPULATED	FREQUENCY C/F/O/R	FUNCTION E/M
35. Computer	F	E	40.		
36. Telephone	F	E	41.		
37.			42.		
38.			43.		
39.					

"C" = continuously [67-100%]; "F" = frequently [34-66%]; "O" = occasionally [6-33%]; "R" = rarely [1-5%].
"E" = essential; "M" = marginal. If it never occurs, leave it blank.

PSYCHOLOGICAL

PSYCHOLOGICAL	FREQUENCY C/F/O/R	FUNCTION E/M
44. Work Alone	F	E
45. Work Around Others	F	E
46. Work Closely With Others	F	E
47. Customer Contact	F	E
48. Limited Supervision	C	E
49. Moderate Supervision	R	E
50. Extensive Supervision	R	E

AUDITORY

AUDITORY	FREQUENCY C/F/O/R	FUNCTION E/M
51. Normal Tones	C	E
52. Soft Tones	C	E

POTENTIAL HAZARDS

POTENTIAL HAZARDS	FREQUENCY C/F/O/R	FUNCTION E/M
53. Mechanical	R	E
54. Electrical	R	E
55. Chemical	R	E
56. Toxins	R	E
57. Moving Objects/Vehicles	O	E
58. Biological	R	E

VISUAL ACUITY

VISUAL ACUITY	FREQUENCY C/F/O/R	FUNCTION E/M
59. Near Vision	F	E
60. Far Vision	F	E
61. Color Perception	F	E
62. Depth Perception	F	E
63. Peripheral Vision	F	E

"C" = continuously [67-100%]; "F" = frequently [34-66%]; "O" = occasionally [6-33%]; "R" = rarely [1-5%].
"E" = essential; "M" = marginal. If it never occurs, leave it blank.

WORK ENVIRONMENT

WORK ENVIRONMENT	FREQUENCY C/F/O/R	FUNCTION E/M	WORK ENVIRONMENT	FREQUENCY C/F/O/R	FUNCTION E/M
64. Hot	R	M	77. Odors	R	M
65. Cold	R	M	78. Team Oriented	C	E
66. Humid	R	M	79. Autonomy Oriented	C	E
67. Damp	R	M	80. Routine Tasks	C	E
68. Wet	R	M	81. Variable Tasks	C	E
69. Dusty	R	M	82. Fast Paced	C	E
70. Dirty	R	M	83. Slow Paced	C	E

WORK ENVIRONMENT	FREQUENCY C/F/O/R	FUNCTION E/M	WORK ENVIRONMENT	FREQUENCY C/F/O/R	FUNCTION E/M
71. Noisy	R	M	84. Variably Paced	C	E
72. Inside	R	M	85.		
73. Outside	R	M	86. Shift 1	C	E
74. Temp Changes	R	M	87. Shift 2	C	E
75. Low Light	R	M	88. Shift 3	C	E
76. Unventilated	R	M			

PHYSICAL MOTION

PHYSICAL MOTION	FREQUENCY C/F/O/R	FUNCTION E/M
89. Hand	F	E
90. Wrist	F	E
91. Elbow	F	E
92. Shoulders	F	E
93. Back	F	E

	2010 @ ADC of 12.5			2010 @ Additional ADC of 12.5		
	I/P Unit	Physicians	Total	I/P Unit	Physicians	Total
Gross revenue	$ 7,536,272	$ 662,089	$ 8,198,360	$ 7,536,272	$ 662,089	$ 8,198,360
Less: contractual allowances	$ (2,801,715)	$ (321,591)	$ (3,123,306)	$ (2,801,715)	$ (321,591)	$ (3,123,306)
Net revenue	$ 4,734,557	$ 340,498	$ 5,075,054	$ 4,734,557	$ 340,498	$ 5,075,054
Expenses:						
Salaries (used 2010 sal/2010 FTEs adjusted for 4563 pt days)	$ 1,475,571	$ 435,187	$ 1,910,758	$ 2,041,794	$ 1,037,998	$ 3,079,793
Fringe Benefits (used 34.22% 2010 fringe benefit %)	$ 504,940	$ 148,921	$ 653,861	$ 698,702	$ 355,203	$ 1,053,905
Supplies (includes temp staffing dollars)	$ 895,967	$ 13,511	$ 909,478	$ 1,696,016	$ 36,899	$ 1,732,914
Bad Debt Expense	$ 629,526	$ 58,182	$ 687,708	$ 629,526	$ 58,182	$ 687,708
Interest Expense (Average for 20 yrs) **(2)**	$ -	$ -	$ -	**$ 813,662**	$ -	$ 813,662
Depreciation Expense (Based on 20 year Life) **(3)**	$ -	$ -	$ -	**$ 1,250,000**	$ -	$ 1,250,000
Incremental Overhead Expenses **(1)**	$ -	$ -	$ -	**$ 1,422,048**	$ -	$ 1,422,048
Salaries - Security (Including Fringe Benefits) **(4)**	$ -	$ -	$ -	$ 114,784	$ -	$ 114,784
Total Expenses	$ 3,506,003	$ 655,801	$ 4,161,804	$ 8,666,532	$ 1,488,282	$ 10,154,814
Net Profit (Loss)	$ 1,228,553	$ (315,303)	$ 913,250	$ (3,931,975)	$ (1,147,784)	$ (5,079,759)
Net to Gross Percentage	62.8%	51.4%	61.9%	62.8%	51.4%	61.9%
Net to Gross Percentage (Including Bad Debt)	54.5%	42.6%	53.5%	54.5%	42.6%	53.5%
Patient Days	4,563	4,563	4,563	4,563	4,563	4,563
Net Revenue (excl. Bad Debt) Per Patient Day	$ 1,038	$ 75	$ 1,112	$ 1,038	$ 75	$ 1,112
Net Revenue (incl. Bad Debt) Per Patient Day	$ 900	$ 62	$ 962	$ 900	$ 62	$ 962
Net Revenue (inc. Bad Debt) Per Patient Day Required to Break Even	$ 630	$ 131	$ 761	$ 1,762	$ 313	$ 2,075
Physician/Psychologist FTEs - PSIU	0.00	2.00	2.00	0.00	5.46	5.46
Non Physician FTEs - PSIU	22.59	0.00	22.59	39.40	0.00	39.40
Temporary Staffing - PSIU	1.83	0.00	1.83	1.68	0.00	1.68
Total FTEs	24.42	2.00	26.42	41.08	5.46	46.55

(1) Incremental Overhead Expenses includes Maintenance and Operation of Plant, Laundry, Housekeeping, Dietary, and Administrative and General including Human Resources and Medical Re
(2) Interest Expense is based on $25 million of debt with a 5.5% interest rate for 20 years
(3) Depreciation Expense is based on $25 million with a 20 year useful life
(4) Represents 3.2 FTEs

Notes:

Operating agreement must be designed to support overall costs

Bad Debt Expense: Based on June 2009 FYTD Payor Mix: Self Pay = 8%

Payer Mix IP Psych Unit FYTD 6/30/09: Medicare- 38%, Medicaid- 39%, BCBS- 8%, Commercial- 7%, Self Pay- 8%